Hepatitis B or C - Case Report Form

INVESTIGATION:

Investigation start date: _____/_____/_____ Investigator name: _____ Phone: (___) _____

Date of 1st Attempt: _____/_____/_____ ☐ Phone ☐ Letter Date of 2nd Attempt: _____/_____/_____ ☐ Phone ☐ Letter

Date of Interview: _____/_____/_____ Reason not interviewed: ☐ Unable to Contact ☐ Refused ☐ Other: _____

PATIENT INFORMATION

Last: _____ First: _____ Middle: _____

If Pediatric Case, Parent/Guardian Name: _____

Address: _____ County: _____ ☐ Homeless

City/State: _____ Zip: _____ Phone: (____) _____

Employer: _____ Occupation/Setting: _____

DEMOGRAPHIC INFORMATION

Date of Birth: _____/_____/_____ Age: _____

Country of Birth: _____

Gender: ☐ Female ☐ Male ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown

Race: ☐ Black/African American
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown Race
☐ Other Race, specify: _____

LABORATORY TESTS

Lab Name: _____ Date of collection:___/___/___

		Pos	Neg	Unk
A.	Total anti-HAV_ _ _ _ _ _	☐	☐	☐
	IgM anti-HAV_ _ _ _ _ _ _	☐	☐	☐
B.	HBsAg_ _ _ _ _ _ _ _ _	☐	☐	☐
	HBeAg_ _ _ _ _ _ _ _ _	☐	☐	☐
	HBV NAT (qual, quant Geno) _ _ _ _ _ _ _	☐	☐	☐
	IgM anti-HBc _ _ _ _ _	☐	☐	☐
C.	anti-HCV_ _ _ _ _ _ _ _	☐	☐	☐
	HCV NAT (qual, quant, Geno) _ _ _ _ _ _ _	☐	☐	☐
	HCVAg _ _ _ _ _ _ _ _	☐	☐	☐
D.	anti-HDV_ _ _ _ _ _ _ _	☐	☐	☐
E.	anti-HEV_ _ _ _ _ _ _ _	☐	☐	☐

CLINICAL & DIAGNOSTIC DATA

Provider Name, Address, and Phone: _____

_____

ILLNESS ONSET DATE: _____/_____/_____

ILLNESS DIAGNOSIS DATE: _____/_____/_____

CLINICAL DATA:

Yes	No	Unk	
☐	☐	☐	_ _ _Symptoms? (fever, headache, malaise, anorexia, n/v, diarrhea, abdominal pain)
☐	☐	☐	_ _ _Jaundiced?
☐	☐	☐	_ _ _Hospitalized for hepatitis? If YES, specify: _____
☐	☐	☐	_ _ _Pregnant? If YES, due date:_____/_____/_____
☐	☐	☐	_ _ _Died from Hepatitis? If YES, date of death:_____/_____/_____

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS:

ALT (SGPT) Result: _____ AST (SGOT) Result: _____

REASON FOR TESTING: *(check all that apply)*

☐ Symptoms of acute hepatitis
☐ Screening of asymptomatic patient with reported risk factors
☐ Screening of asymptomatic patient with no risk factors
☐ Prenatal screening
☐ Evaluation of elevated liver enzymes
☐ Blood/Organ donor screening
☐ Follow-up testing for previous marker of viral hepatitis
☐ Unknown
☐ Other: specify:_____

CASE CLASSIFICATION

Hepatitis B

I	II	III	IV
☐ Symptomatic	☐ Jaundice and/or ALT >100	☐ HBsAg (+)	☐ IgM anti-HBc (+)

☐ **Acute, Confirmed**:

- Seroconversion: (-) HBsAg within 6mos prior to a (+) HBsAg, HBeAg/HBV NAT; OR
- All Boxes checked (I, II, III, and IV) OR
- Boxes I, II, and III checked with unknown IgM anti-HBc

☐ **Acute, Probable**:

- [Box I, and/or Box II], plus Box III checked with unknown IgM anti-HBc*; OR
- Boxes III and IV checked

☐ **Chronic, Confirmed**:

- (-) IgM anti-HBc and one (+) of the following: HBsAg, HBeAg, or HBV NAT; OR
- (+) HBsAg, HBeAg, HBV NAT two times ≥ 6 months apart (any combo)

☐ **Chronic, Probable**:

- One (+) of the following : HBsAg, HBeAg, or HBV NAT

Hepatitis C

	Symptom(s) **plus** either **a)** jaundice or **b)** ALT >200 IU/L	
	No or unknown	Yes
HCV Ab(+) only	**Chronic, Probable** ☐	**Acute, Probable** ☐
HCV NAT(+) or HCV Ag(+)	**Chronic, Confirmed** ☐	**Acute, Confirmed** ☐

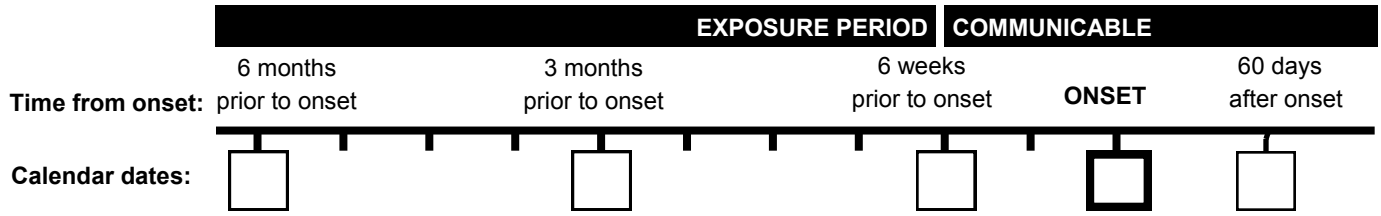
Acute, Confirmed:

- Seroconversion: (-) HCV Ab, HCV Ag, or HCV NAT followed by a (+) of any of these within 12 months

PATIENT HISTORY - ACUTE HEPATITIS B ONLY **CASE NAME:** _____

INFECTION TIMELINE

Enter onset date in heavy box. Count forwards and backwards to calculate the probable exposure and communicable periods. Ask about exposures between those dates. For ***Hepatitis B***, exposure period is **6 months to 6 weeks** prior to onset (onset=symptoms or, in the absence of symptoms, first positive lab prior to onset). Patient is infectious until clearance of HBsAg — about 60 days after onset of symptoms for most adults and indefinitely for carriers.



*Items in italics are interviewer instructions; items in **bold** indicate script prompts:*

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

First, I would like to ask you a few questions about exposures you may have had in the 6 month to 6 week period before the onset of illness. I will need to ask you questions about various items, including social contacts, sexual contacts, tattoos, piercings, and potential drug use. *(Remind patient of date range collected from timeline.)*

In the 6 months to 6 weeks before your onset of illness:

Yes No Unk

☐ ☐ ☐ _ _ _ **Were you**: A contact of a person with Hepatitis B?
If YES, type of contact:
- ☐ Sexual
- ☐ Needle
- ☐ Household (non-sexual)
- ☐ Other: _____

☐ ☐ ☐ _ _ _ Diabetic?
Diabetes Diagnosis Date: _____
If YES, *(check all the apply)*
- ☐ Use a blood glucose monitor
- ☐ Share a blood glucose monitor
- ☐ Inject Insulin
- ☐ Share syringes or needles

☐ ☐ ☐ _ _ _ **Did you:** Undergo hemodialysis?

☐ ☐ ☐ _ _ _ Have an accidental stick or puncture with a needle or other object contaminated with blood?

☐ ☐ ☐ _ _ _ Receive blood or blood products (transfusion)?
If YES, when? _____/_____/_____

☐ ☐ ☐ _ _ _ Receive any IV infusions or injections in the outpatient setting?

☐ ☐ ☐ _ _ _ Have other exposure to someone else's blood?
Specify: _____

☐ ☐ ☐ _ _ _ **Were you:** Employed in a medical or dental field involving direct contact with human blood?
If YES, frequency of direct blood contact:
- ☐ Frequent (several times weekly)
- ☐ Infrequent

☐ ☐ ☐ _ _ _ Employed as a public safety worker (fire, police, corrections) involving direct contact with human blood?
If YES, frequency of direct contact:
- ☐ Frequent (several times weekly)
- ☐ Infrequent

Yes No Unk

☐ ☐ ☐ _ _ _ **Did you:** Receive a tattoo?
If YES, where was it performed?
- ☐ Commercial/Parlor
- ☐ Correctional facility
- ☐ Self
- ☐ Other: _____

☐ ☐ ☐ _ _ _ Receive any body piercing (other than ear)?
If YES, where was it performed?
- ☐ Commercial/Parlor
- ☐ Correctional Facility
- ☐ Self
- ☐ Other: _____

☐ ☐ ☐ _ _ _ **Did you:** Have dental work or oral surgery?

☐ ☐ ☐ _ _ _ Have any other surgery (other than oral)?

☐ ☐ ☐ _ _ _ **Were you:** Hospitalized?
If YES, name of Hospital: _____

☐ ☐ ☐ _ _ _ A resident of a long-term care facility?

☐ ☐ ☐ _ _ _ Incarcerated for longer than 24 hours?
If YES, what type of facility?
- ☐ Prison
- ☐ Jail
- ☐ Juvenile Facility

☐ ☐ ☐ _ _ _ **Did you:** Inject drugs not prescribed by a doctor?

☐ ☐ ☐ _ _ _ Use street drugs but not inject?

☐ ☐ ☐ _ _ _ Have any sexual contact?
If YES, number of Male sexual partners?
☐ 0 ☐ 1 ☐ 2– 5 ☐ >5 ☐ Unk
If YES, number of Female sexual partners?
☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unk

During your lifetime, were you EVER:

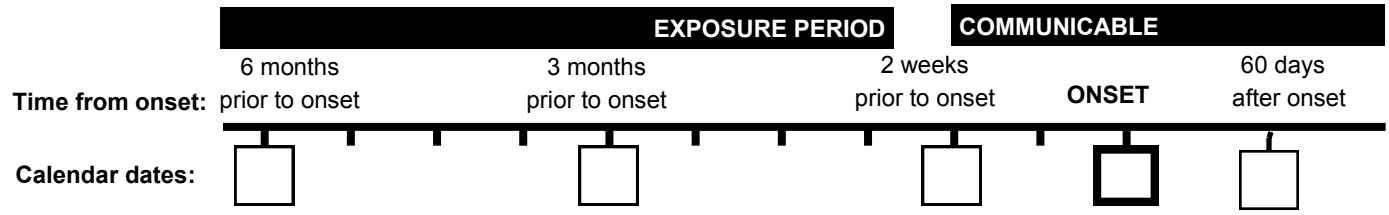
☐ ☐ ☐ _ _ _ Treated for sexually transmitted diseases?
If YES, year of most recent treatment: _____

☐ ☐ ☐ _ _ _ Incarcerated for longer than 6 months?
If YES, year incarceration completed? _____
For how many months? _____

PATIENT HISTORY - ACUTE HEPATITIS C ONLY **CASE NAME:** _____

INFECTION TIMELINE

Enter onset date in heavy box. Count forwards and backwards to calculate the probable exposure and communicable periods. Ask about exposures between those dates. For ***Hepatitis C***, exposure period is **6 months to 2 weeks** prior to onset on-set=symptoms or, in the absence of symptoms, first positive lab prior to onset). Patient is infectious until clearance of HCV.



*Items in italics are interviewer instructions; items in **bold** indicate script prompts:*

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

First, I would like to ask you a few questions about exposures you may have had in the 6 month to 2 week period before your onset of illness. I will need to ask you questions about various items, including social contacts, sexual contacts, tattoos, piercings, and potential drug use. *(Remind patient of date range collected from timeline.)*

In the 6 months to 2 weeks before your onset of illness:

Yes No Unk

☐ ☐ ☐ _ _ _ **Were you**: A contact of a person with Hepatitis C?
If YES, type of contact:
- ☐ Sexual
- ☐ Needle
- ☐ Household (non-sexual)
- ☐ Other: _____

☐ ☐ ☐ _ _ _ Diabetic?
Diabetes Diagnosis Date: _____
If YES, *(check all the apply)*
- ☐ Use a blood glucose monitor
- ☐ Share a blood glucose monitor
- ☐ Inject Insulin
- ☐ Share syringes or needles

☐ ☐ ☐ _ _ _ **Did you:** Undergo hemodialysis?

☐ ☐ ☐ _ _ _ Have an accidental stick or puncture with a needle or other object contaminated with blood?

☐ ☐ ☐ _ _ _ Receive blood or blood products (transfusion)?
If YES, when? _____/_____/_____

☐ ☐ ☐ _ _ _ Receive any IV infusions or injections in the outpatient setting?

☐ ☐ ☐ _ _ _ Have other exposure to someone else's blood?
Specify: _____

☐ ☐ ☐ _ _ _ **Were you:** Employed in a medical or dental field involving direct contact with human blood?
If YES, frequency of direct blood contact:
- ☐ Frequent (several times weekly)
- ☐ Infrequent

☐ ☐ ☐ _ _ _ Employed as a public safety worker (fire, police, corrections) involving direct contact with human blood?
If YES, frequency of direct contact:
- ☐ Frequent (several times weekly)
- ☐ Infrequent

Yes No Unk

☐ ☐ ☐ _ _ _ **Did you:** Receive a tattoo?
If YES, where was it performed?
- ☐ Commercial/Parlor
- ☐ Correctional facility
- ☐ Self
- ☐ Other: _____

☐ ☐ ☐ _ _ _ Receive any body piercing (other than ear)?
If YES, where was it performed?
- ☐ Commercial/Parlor
- ☐ Correctional Facility
- ☐ Self
- ☐ Other: _____

☐ ☐ ☐ _ _ _ **Did you:** Have dental work or oral surgery?

☐ ☐ ☐ _ _ _ Have any other surgery (other than oral)?

☐ ☐ ☐ _ _ _ **Were you:** Hospitalized?
If YES, name of Hospital: _____

☐ ☐ ☐ _ _ _ A resident of a long-term care facility?

☐ ☐ ☐ _ _ _ Incarcerated for longer than 24 hours?
If YES, what type of facility?
- ☐ Prison
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- ☐ Juvenile Facility

☐ ☐ ☐ _ _ _ **Did you:** Inject drugs not prescribed by a doctor?

☐ ☐ ☐ _ _ _ Use street drugs but not inject?

☐ ☐ ☐ _ _ _ Have any sexual contact?
If YES, number of Male sexual partners?
☐ 0 ☐ 1 ☐ 2– 5 ☐ >5 ☐ Unk
If YES, number of Female sexual partners?
☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unk

During your lifetime, were you EVER:

☐ ☐ ☐ _ _ _ Treated for sexually transmitted diseases?
If YES, year of most recent treatment: _____

☐ ☐ ☐ _ _ _ Incarcerated for longer than 6 months?
If YES, year incarceration completed? _____
For how many months? _____

COMPLETE FOR ALL HEPATITIS CASE CLASSIFICATIONS **CASE NAME:** _____

CONTACT MANAGEMENT

*Items in italics are interviewer instructions; items in **bold** indicate script prompts:* **I would like you to think about the risk factors we discussed. Can you provide any contacts such as household, sexual, needle sharing, tattoo equipment sharing, and others you may have been in close contact with during the period before your illness onset** (onset=symptoms or, in the absence of symptoms, first positive lab prior to onset)**?** *(Remind patient of date range collected from timeline.)* **I assure you that your information will be kept confidential.**

CONTACTS:	**CONTACT FOLLOW-UP:** (*to be completed after interview)*
1. Name: _____ Gender: ☐ Female ☐ Male Age: _____ Relation to case: *(check all that apply)* ☐ Household ☐ Sexual ☐ Needle sharing ☐ Tattoo equipment sharing ☐ Other, specify: _____ Date of last exposure to contact: ___/___/___ Address: _____ State: _____ Phone number: (___) _____	1. Name: _____ Date of 1st attempt: ___/___/___ Date of 2nd attempt: ___/___/___ Date of interview: ___/___/___ Reason not interviewed: ☐ Unable to contact ☐ Refused Date of birth: ___/___/___ Occupation: _____ Check all that apply: ☐ Symptomatic, onset date: ___/___/___ ☐ Asymptomatic ☐ Tested positive ☐ Tested negative ☐ Not tested ☐ Vaccinated ☐ Not vaccinated Education provided: ☐ Yes ☐ None, reason: _____
2. Name: _____ Gender: ☐ Female ☐ Male Age: _____ Relation to case: *(check all that apply)* ☐ Household ☐ Sexual ☐ Needle sharing ☐ Tattoo equipment sharing ☐ Other, specify: _____ Date of last exposure to contact: ___/___/___ Address: _____ State: _____ Phone number: (___) _____	2. Name: _____ Date of 1st attempt: ___/___/___ Date of 2nd attempt: ___/___/___ Date of interview: ___/___/___ Reason not interviewed: ☐ Unable to contact ☐ Refused Date of birth: ___/___/___ Occupation: _____ Check all that apply: ☐ Symptomatic, onset date: ___/___/___ ☐ Asymptomatic ☐ Tested positive ☐ Tested negative ☐ Not tested ☐ Vaccinated ☐ Not vaccinated Education provided: ☐ Yes ☐ None, reason: _____
3. Name: _____ Gender: ☐ Female ☐ Male Age: _____ Relation to case: *(check all that apply)* ☐ Household ☐ Sexual ☐ Needle sharing ☐ Tattoo equipment sharing ☐ Other, specify: _____ Date of last exposure to contact: ___/___/___ Address: _____ State: _____ Phone number: (___) _____	3. Name: _____ Date of 1st attempt: ___/___/___ Date of 2nd attempt: ___/___/___ Date of interview: ___/___/___ Reason not interviewed: ☐ Unable to contact ☐ Refused Date of birth: ___/___/___ Occupation: _____ Check all that apply: ☐ Symptomatic, onset date: ___/___/___ ☐ Asymptomatic ☐ Tested positive ☐ Tested negative ☐ Not tested ☐ Vaccinated ☐ Not vaccinated Education provided: ☐ Yes ☐ None, reason: _____
4. Name: _____ Gender: ☐ Female ☐ Male Age: _____ Relation to case: *(check all that apply)* ☐ Household ☐ Sexual ☐ Needle sharing ☐ Tattoo equipment sharing ☐ Other, specify: _____ Date of last exposure to contact: ___/___/___ Address: _____ State: _____ Phone number: (___) _____	4. Name: _____ Date of 1st attempt: ___/___/___ Date of 2nd attempt: ___/___/___ Date of interview: ___/___/___ Reason not interviewed: ☐ Unable to contact ☐ Refused Date of birth: ___/___/___ Occupation: _____ Check all that apply: ☐ Symptomatic, onset date: ___/___/___ ☐ Asymptomatic ☐ Tested positive ☐ Tested negative ☐ Not tested ☐ Vaccinated ☐ Not vaccinated Education provided: ☐ Yes ☐ None, reason: _____

Thank you for your patience and providing your information. As a reminder, your information will be kept confidential. Please give me a moment to review. This information is very useful to prevent further transmission. *(Continue to next page)*

COMPLETE FOR ALL HEPATITIS CASE CLASSIFICATIONS **CASE NAME:** _____

EDUCATION AND PREVENTION MEASURES

Yes	No	N/A	
☐	☐	☐	_ _ _Did patient complete 3-shot Hepatitis B vaccine series?

If YES,

Vaccine Type	*Date*	*Provider/Phone*	*Verified*
_____	___/___/___	_____	☐ Yes ☐ No
_____	___/___/___	_____	☐ Yes ☐ No
_____	___/___/___	_____	☐ Yes ☐ No

If NO, Hepatitis B vaccination recommended?
- ☐ Yes, recommended
- ☐ No, specify reason: _____

☐ ☐ ☐ _ _ _Hepatitis A vaccination recommended?

☐ ☐ ☐ _ _ _Is patient pregnant?

If YES, refer patient to perinatal coordinator *(see public health action list below).*

☐ ☐ ☐ _ _ _If case is less than 2 years old, was Hepatitis B acquired as a result of perinatal transmission?
If YES, Mother's name: _____

☐ ☐ ☐ _ _ _Did patient donate blood products, organs, or tissue? (including ova and semen)
If YES, Date: _____/_____/_____ Location: _____

☐ ☐ ☐ _ _ _Case education provided on? (*Check all that apply)*
- ☐ Not donating blood products, organs, or tissue while infected? (including ova and semen)
- ☐ Measures to avoid transmission
- ☐ Avoidance of liver toxins (e.g., alcohol, Tylenol)
- ☐ For females, counseling on need for follow-up on any future pregnancies
- ☐ For healthcare workers, counseling on safety and transmission
- ☐ Possibility of chronic infection from acute status (i.e., ongoing infection)

☐ ☐ ☐ _ _ _Other education provided?
If YES, specify:_____
_____

PUBLIC HEALTH ACTIONS

(Check all that apply)

☐ Prophylaxis (HBIG) of appropriate contacts recommended
Number recommended prophylaxis:_____

☐ Vaccination of appropriate contacts recommended
Number recommended vaccination:_____

☐ Contact management follow-up completed

☐ Pregnant patient referred to Perinatal Coordinator
Estimated Date of Delivery: _____/_____/_____
Perinatal Case Number: _____

NOTES & COMMENTS

Investigator: _____ Phone: (____) _____ Investigation complete date: _____/_____/_____